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North Carolina

Medicaid Pharmacy

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In This Issue...

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North Carolina Behavioral Pharmacy Management Project

The North Carolina Department of Health and Human Services has launched an innovative educational program that strives to improve the quality of care for Medicaid patients with mental illness.

North Carolina Behavioral Pharmacy Management Project will analyze the prescribing of mental health medications for Medicaid members and identify prescribing patterns inconsistent with evidence-based guidelines. When needed, physicians will be provided with educational materials and client survey information as well as peer-to-peer consultation.

The project is a collaborative effort that involves the Division of Medical Assistance and the Division of Mental Health/Substance Abuse and Developmental Disabilities and Comprehensive NeuroScience, Inc. (CNS). Eli Lilly and Company is providing funding in support of the independent program. The North Carolina Physician's Advisory Group will serve as an advisor to the project.

The process begins with a review by CNS of Medicaid patient pharmacy claims data to identify prescribing and utilization trends for mental health and psychotropic medications. The researchers will look at such categories as multiple medication prescribing in the same therapeutic class, prescribing above or below FDA-recommended dosing levels, failure of patients to fill their prescriptions in a timely fashion and patients with two or more physicians prescribing the same medications during the identical time period. Prescriptions that fall within these categories will then be compared with best practices guidelines.

Information as to which pharmacy a prescriber's patient is having their prescriptions filled will be noted on the prescriber's Patient Detail Report. The pharmacy's phone number will also be listed. A pharmacy may therefore be contacted by a physician in regards to this project.

The state expects the CNS review of prescribing practices to identify a small group of doctors who regularly fall outside of guidelines. These physicians will receive educational materials promoting adherence to the best practices guidelines. In addition, CNS will continue to monitor physicians for the duration of the program to determine whether prescribing problems improve.

The prescription monitoring program is working in several other states, including Missouri, where an analysis from the program's first year shows a 98 percent reduction of patients who are prescribed the same mental health medications from multiple doctors; a 64 percent reduction of patients who are on two or more mental health medications of the same type; a 43 percent reduction of children on three or more psychotropic medications; and, a 40 percent reduction of patients receiving an unusually high dosage of medication.

CMS Process to Ensure Effective Transition to Medicare Part D

In spite of all best efforts to identify and auto-enroll dual eligible individuals prior to the effective date of their Medicare Part D eligibility, it is possible that some individuals may show up at pharmacies before they have been auto-enrolled. For this reason, CMS has developed a process for a point-of-sale solution to ensure full dual eligible individuals experience no coverage gap. They have established a process whereby beneficiaries who present at a pharmacy with evidence of both Medicaid and Medicare eligibility, but without current enrollment in a Part D plan, can

have the claim for their medication submitted to a single account for payment. The beneficiary can leave the pharmacy with a prescription, and a CMS contractor will immediately follow up to validate eligibility and facilitate enrollment into a Part D plan.

In order for this process to operate effectively there must be a uniform and straightforward set of instructions that all pharmacists can follow no matter which plan networks they are in or where they are in the country. This requires a single account administered by one payer. In addition, a national plan that offers a basic plan for a premium at or below the regional low-income premium subsidy amount in every PDP region will be able to both process the initial prescription (generally at in-network rates) and enroll the beneficiary in a matter of days, thus eliminating any gap in coverage. Therefore, CMS has contracted with Wellpoint, an approved national PDP, to manage a single national account for payment of prescription drug claims for the very limited number of dual eligible beneficiaries who have not yet been auto-enrolled into a Part D plan at the time they present a prescription to a pharmacy.

Further details on our Point-of-Sale (POS) Facilitated Enrollment process are provided below:

What will this process look like?

1. Full dual presents at the pharmacy with either a Medicaid card, or previous history of Medicaid billing in the pharmacy system patient profile.

2. Pharmacist bills Medicaid and the claim is denied.

3. Pharmacist requests photo identification and checks for Part D enrollment by submitting an E1 query to the TROOP facilitator; pharmacist also checks for A/B Medicare eligibility by:

   Requesting to see a Medicare card; Calling dedicated eligibility line at 1-866-835-7595; Calling 1-800-MEDICARE; or Requesting to see the Medicare Summary Notice (MSN)

4. If the E1 query returns Part D plan enrollment information, the pharmacist bills the appropriate plan. Otherwise, this process continues only if the pharmacist can not identify the appropriate plan to bill and the pharmacist is able to verify both Medicaid eligibility (step 1) and Medicare eligibility (step 3)

5. The Pharmacist enters the claim into the automated pharmacy system, including available data on the beneficiary as to name and ID number (HICN, Medicaid ID number, or SSN), as well as date of birth, address, and phone number. Note that pharmacies routinely collect this information at point-of-sale anyway in accordance with state pharmacy laws.

6. Pharmacist submits the claim to the single pre-established service account indicated on the POS Contractors payer sheet, and in response to the paid claim response provides the prescription drug to the beneficiary at the $1/$3 cost sharing level.

7. The POS Contractor (Wellpoint) processes the claim as paid (network pharmacies) or as a captured response (out-of-network pharmacy).

8. If the pharmacy is out-of-network then special instructions would be sent to the pharmacy to establish the mechanism for payment.

9. The POS Contractor (Wellpoint) sends a daily file to the Enrollment Contractor (Z-Tech) on the beneficiary data submitted with these paid claims.

10. The Enrollment Contractor (Z-Tech) uses this information to validate dual eligibility via access to CMS and state systems and returns validation of eligibility or ineligibility to the POS Contractor (Wellpoint).

11. If the individual is verified to have dual eligibility and has not been enrolled in a Part D plan, the POS Contractor (Wellpoint) would immediately submit an enrollment transaction on behalf of the dual to enroll him/her to a POS Contractor (Wellpoint) plan retroactively. Normal rules for duals opting out of the plan would apply.

12. If the beneficiary is a full dual and already enrolled in a Part D plan, the claim will be reversed and the pharmacy will bill the appropriate Part D plan.

13. If the beneficiary is Medicaid only, the claim will be reversed and the pharmacy will bill the appropriate state agency.

14. If the person claiming dual status is found to be Medicare eligible only, the Enrollment Contractor (Z-Tech) will notify the beneficiary by letter that s/he is ineligible for the facilitated enrollment service but may enroll in a Part D plan under normal enrollment rules, and the claim will be reversed to the pharmacy for collection.

Coverage Information for the Excluded Drug Classes under Medicare Part D

Beginning January 1, 2006, Medicaid recipients with Medicare will start receiving their drugs through a Prescription Drug Plan (PDP). The PDP's will have formularies of drugs that are covered and noncovered. If a client needs a noncovered drug, Medicaid will not pay for the drug. The client will have to work with their PDP to get the drug covered or switch to another drug on the PDP's formulary.

There are classes of drugs that federal regulations do not require PDP formularies to cover. These classes of drugs are referred to as excluded drugs. Medicaid currently covers a subset of these excluded drugs and will continue to cover them for all Medicaid recipients after January 2006. The following criteria will be used in determining the drugs that will be covered by Medicaid once Medicare Part D is implemented on January 1, 2006:

There will be no coverage for the following excluded drug classes:

1. Agents Used for Anorexia, Weight Loss, Weight Gain
2. Agents Used to Promote Fertility
3. Agents Used for Cosmetic Purposes or Hair Growth

4. Covered Outpatient Drugs which the Manufacturer Seeks to Require as a Condition of Sale that Associated Tests or Monitoring Services be Purchased Exclusively from the Manufacturer or its Designee.

There will be coverage for the following excluded drug classes if there is a rebate agreement with CMS and if the drug is a legend drug:

1. Agents Used for the Symptomatic Relief of Cough and Colds (must contain an expectorant or cough suppressant)
2. Prescription Vitamins and Mineral Products, Except Prenatal Vitamins and Fluoride
3. Barbiturates
4. Benzodiazepines
5. Nonprescription drugs under NC DMA General Clinical Policy A2

All claims should be submitted to the PDP first to ensure that they are not covering these products. If denied, the claim can then be submitted to Medicaid with a "03" (other coverage exists-this claim not covered) in the other coverage code field. In situations where the claim must be filed on paper, use an 'O' in the family planning field to indicate that the PDP was billed first.

If the drug is covered by Medicare Part B, but not covered for the recipient's diagnosis, then the claim should be billed to the PDP.

The PDPs will have a prior approval (PA) process to handle this type of situation. The override for the Medicare part B edit will be discontinued effective January 1, 2006. Medicaid will pay the remaining amount if Medicare pays first (based on the Medicare allowable), but Medicaid will no longer be a primary payer for Part B drugs when not covered for the recipient's diagnosis.

More information regarding the Medicare Part D changes can be found on the website : http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/

Denial on Medicaid Covered Excluded Drugs

Pharmacy providers receiving a denial on a Medicaid covered excluded drug for a Medicaid eligible recipient after the Medicare Part D prescription drug program begins on January 1, 2006 may contact the EDS pharmacy unit to check for coverage status of the drug at 919-851-8888 or 1-800-688-6696.

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Informed Decisions Beneficiary Centered Enrollment Service

The Informed Decisions Beneficiary Centered Enrollment (BCE) project as described in the November 2005 Pharmacy Newsletter will be delayed and this service will not be available at this time. More information will be announced in future newsletters.

Medicare Part D - Long-Term Care Fax System

In addition to using the web-based Prescription Plan Finder tool at www.Medicare.gov for individual resident inquiries, nursing homes without Internet access or those who need Medicare prescription drug plan enrollment information for multiple residents can now do so via a special CMS fax-based procedure.

Nursing homes should provide the required authentication information for each of their Medicare residents using the attached authentication form. Send the completed form, along with a fax-back cover sheet (sample attached) including the name and phone number of a voice contact, to Medicare at:

1-785-830-2593.

Medicare customer service representatives will process the requests and fax them back to the nursing home within three (3) business days. Please use these forms to expedite your request. Failing to follow this approach will cause a delay in the ability to respond.

Nursing Home Actions and Instructions:

1. Information should be for multiple beneficiaries and all the names may be included on a single request form.

2. Nursing home representatives will supply the required authentication information for each patient they are requesting information on to 1-800-MEDICARE via fax. The required authentication information includes:

   - Beneficiary Name
   - HIC #
   - Date of Birth
   - Address
   - Entitled to Part A or B (yes or no)

3. Use a Fax Cover Sheet to transmit the completed authentication form. CMS will fax back your Fax Cover Sheet with the patient Medicare prescription drug plan enrollment information. A sample Fax Cover Sheet is attached.

4. The Fax Cover Sheet must contain the following attestation statement signed by a nursing home representative:

   I attest that the Medicare prescription drug plan enrollment information to be provided by CMS about patients on the attached list will be used by the nursing home only for Medicare prescription drug coverage purposes.

5. The Fax Cover Sheet must also contain the following:

   - a fax number for returning the requested Medicare prescription drug plan enrollment information to the nursing home

- the name and phone number of a nursing home contact in case there are questions.

6. Use the following safeguards when faxing to CMS' secure site:

   - include a disclaimer on the Fax Cover Sheet (see attached sample Fax Cover Sheet)
   - get the transmission confirmation after the fax is sent

   Do NOT put individually identifiable or sensitive information on the Fax Cover Sheet.

Medicare Customer Service Representative Actions:

1. Medicare CSRs will process these requests and fax them back to the nursing home within three (3) business days.

2. Due to privacy concerns, information faxed back to nursing homes will include only the first initial, last name, and prescription drug plan enrollment information for each beneficiary.

Fax Cover Sheet

CMS Medicare Prescription Drug Plan Enrollment Information Request

Date: _____

Fax Back Number: Area Code ( ) _____

Voice Contact Name: _____

Voice Contact Phone #: _____

Number of pages (including cover sheet): _____

Identification:
Institution Name: _____
Medicare Billing Number: _____
Comments:

Attestation:
I attest that the Medicare Prescription Drug Plan enrollment information to be provided by the Centers for Medicare & Medicaid Services (CMS) will be used by the nursing home only for Medicare prescription drug coverage purposes.

_____
Signature of Nursing Home Representative

The attached information is CONFIDENTIAL and is intended only for the use of the addressee(s) identified above. If the reader of this message is not the intended recipient(s) or the employee or agency responsible for delivering the message to the intended recipient(s), please note that any dissemination, distribution, or copying of the communication is strictly prohibited. Anyone who receives this communication in error should notify us immediately by telephone and return the original message to us at the address above via U.S. Mail. Thank you.

Fax request to Medicare at (785)-830-2593.

Administrative Update for Synagis Claims Processing

The following information should serve as clarification to the current administrative process for Synagis claims processing:

North Carolina Medicaid should not be billed for Synagis claims unless there is an accurate and complete 2005-2006 Synagis criteria form on file in the pharmacy or a Synagis Medical Review Outside of Criteria form for season 2005-2006 that has been reviewed and approved by DMA on file in the pharmacy. Payment of Synagis claims **for dates of service** prior to October 10, 2005 and after March 15, 2006 will not be allowed and will be subject to recoupment by Program Integrity.

Synagis doses that include multiple vial strengths must be submitted to North Carolina Medicaid as a single compound drug claim. Synagis doses that require multiple vial strengths that are submitted as individual claims will be subject to recoupment by Program Integrity.

Changes in Drug Rebate Manufacturers

Additions

The following labelers have entered into Drug Rebate Agreements and joined the rebate program effective on the dates indicated below:

Code	***Manufacturer***	***Date***
15330	Genpharm, L.P	11/29/2005

Reinstated Labeler

Ranbaxy Laboratories Inc. (Labeler code 10631) has signed a new rebate agreement with a mandatory coverage effective date of 10/01/2005. There is no optional coverage date for this reinstated labeler.

HAPPY HOLIDAYS !

Checkwrite Schedule

January 06, 2006	February 07, 2006	March 07, 2006
January 10, 2006	February 14, 2006	March 14, 2006
January 18, 2006	February 23, 2006	March 21, 2006
January 26, 2006		March 30, 2006

Electronic Cut-Off Schedule

January 06, 2006	February 03, 2006	March 03, 2006
January 13, 2005	February 10, 2006	March 10, 2006
January 20, 2005	February 17, 2006	March 17, 2006
January 27, 2005		March 24, 2006

Electronic claims must be transmitted and completed by 5:00 p.m. on the cut-off date to be included in the next checkwrite. Any claims transmitted after 5:00 p.m. will be processed on the second checkwrite following the transmission date. POS claims must be transmitted and completed by 12:00 midnight on the day prior to the electronic cut-off date to be included in the next checkwrite.

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